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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12-12-52

STATE OF TEXAS
COUNTY OF DALLAS

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|--|
| FOR STATE REGISTRAR | | | | | REG. NO. 79-12456 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Edna Mabel Bond | | | | | 2a. DATE OF DEATH May 13, 1979 | | | 2b. HOUR 6:30 AM | |
| 3. SEX Female | | 4. RACE Negro | | 5. DATE OF BIRTH April 9, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD. | | | |
| 10. CITY OR TOWN OF DEATH Chestertown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Kent | | 13c. CITY OR TOWN Chestertown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 402 Calvert Street | |
| 14. FATHER'S NAME John Douglas Johnson | | | | | 15. MOTHER'S MAIDEN NAME Mary Hallie Dickerson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-36-1830 | | 17. INFORMANT ADDRESS Hospital Records, Chestertown, Maryland 21620 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomyopathy</u> 4054 DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardiac artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>congestive heart failure</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 5, 1979, to May 13, 1979, that (I) (we) lost saw the deceased alive on May 13, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Harry Paul Ross, M.D. | | | | | | | | 22c. DATE SIGNED 5-21-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harry Paul Ross, M.D. | | | | 22e. ADDRESS Chestertown, Maryland 21620 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5-19-1979 | | 23c. NAME OF CEMETERY OR CREMATORY JANESCEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE CHESTER TOWN KENT MD. | | | |
| 24. FUNERAL DIRECTOR NAME Kenneth Wally | | | | ADDRESS CHESTER TOWN | | 25a. DATE REC'D. BY REGISTRAR MAY 23 1979 | | 25b. REGISTRAR'S SIGNATURE Lillian M. Hardy | |

BP

13-15128

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-12457

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ida Viola Bowers | | 2a. DATE OF DEATH MONTH DAY YEAR May 9, 1979 | | 2b. HOUR P M 3:30 P | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 9 - 10 - 1885 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD. | |
| 10. CITY OR TOWN OF DEATH Chestertown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Asst. Post Mistress Postal Service | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Queen Anne | | 13c. CITY OR TOWN Crumpton | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel ? Wallen | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Elizabeth Butter | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | |
| 16b. SOCIAL SECURITY NO. 220-10-8222A | | 17. INFORMANT ADDRESS Hospital Records-Chestertown, Maryland 21620 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pancytopenia et c/o unknown</u> 2848 DUE TO, OR AS A CONSEQUENCE OF: (b) <u>multiple petechias + ecchymoses</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>advanced age</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 weeks | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>advanced age</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22. I certify that (I) (this hospital) attended the deceased from <u>May 4</u> , 19 <u>79</u> , to <u>May 9</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>May 9</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did) (did not) view the body after death. | | | |
| 22a. SIGNATURE <u>Harry P. Ross, MD</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Harry P. Ross, M.D. | | 22d. ADDRESS Chestertown, Maryland 21620 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-12-79 | | 23c. NAME OF CEMETERY OR CREMATORY Crumpton Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY Crumpton Queen Anne, Md. | | 24. FUNERAL DIRECTOR NAME Helfenbein-Hubbard F.H. ADDRESS Chester, Md. 21619 | | | |
| 25a. DATE REC'D. BY REGISTRAR MAY 18 1979 | | 25b. REGISTRAR'S SIGNATURE | | | |

13-15123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | 79-12458 REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Oliver Boyer | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 31 1979 | | | 2b. HOUR 10:38P.M. M | |
| 3. SEX Male | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR March 15 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD. | | | |
| 10. CITY OR TOWN OF DEATH Chestertown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent And Queen Anne's Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Box #308 | | |
| 13a. STATE Maryland | | 13b. COUNTY Kent | | 13c. CITY OR TOWN Worton | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Carl NMN Boyer DEC. | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary NMN Johnson DEC. 21620 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-10-7387 | | 17. INFORMANT ADDRESS Hospital Records Chestertown, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> 4275 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe COPD -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Chronic Kidney Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Heart Failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 07 79, to May 31 79, that (I) (we) lost saw the deceased alive on May 31 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Patrick A. Molony</u> DEGREE | | | | | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick A. Molony, M.D. | |
| 22e. ADDRESS Chestertown, Maryland 21620 | | | | | | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 6/4/79 | | 23c. NAME OF CEMETERY OR CREMATORY Bigwoods Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE near Lynch, Md. | | |
| 24. FUNERAL DIRECTOR NAME James A. Perkins | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 4 1979 | | 25b. REGISTRAR'S SIGNATURE <u>Patrick A. Molony</u> | |

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FACT-51-315

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|---|--|---------|--|--|--|------------------------------------|--|---|--|------------------|--|---|--|-------|--|---|--|------|--|------------------------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR P | | | | | | | |
| HENRY JAMES CRAVENS | | | | | | | | xx | | 5/28/79 | | 19 | | 2:30 | | AM | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR P | | | |
| male | | white | | 9/6/17 | | 61 YRS. | | MONTHS | | DAYS | | HOURS | | MIN | | 5/28/79 | | 19 | | 3:30 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Ill | | | | USA | | | | | | | | Kent Co. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| RFD Chestertown | | | | At Home Tplchester Est. | | | | Eng. for RCA | | | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE | | | | 13b. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | | | | | |
| New Jersey | | | | Camden | | | | Somerdale | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 716 Mildred Ave. | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | | | | |
| Harvey Henry Cravens | | | | Delpha Mae Adams | | | | yes | | | | WW 2 | | | | 358 10 8582 | | | | Mrs. Chas. R. Johnston | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: | | | | IMMEDIATE CAUSE (a) | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | Vascular Disease | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 4292 | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | 5/28/79 | | | | | | | |
| Robert W. Farr | | | | Kent County | | | | Chestertown, Md. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Burial | | | | 5-31-79 | | | | Fort Lincoln Cemetery | | | | Colmar Manor, Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| J. Wells Wells | | | | JUN 1 1979 | | | | J. Wells Wells | | | | | | | | | | | | | | | |

82-15128

Sourcefile

8/2/82

Printed 2-31-79 Fort Lincoln Cemetery Colver Manor, MI

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-12460

| | | | | | | | | |
|--|--------------------------|---|---|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) George Lester Graves | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 5/17/79 | | | 2b. HOUR 2:15 | | |
| 3 SEX male | 4 RACE colored | 5. DATE OF BIRTH MONTH DAY YEAR 3/13/1915 | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD 5/17/79 | 7d. HOUR 3 A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Kent | | |
| 10. CITY OR TOWN OF DEATH Chestertown | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RFD Airport Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer - Various | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md. | | 13b. COUNTY Kent | 13c. CITY OR TOWN Chestertown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS RFD | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Graves | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MRS. Alice Demby Chesler | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) — | | 17. INFORMANT ADDRESS MRS. Alice Demby Chesler RFD #4 Chestertown Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) NATURAL CAUSES - PROBABLY DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 410 - ACUTE MYOCARDIAL INFARCT (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE Harry Paul Ross | | TITLE (SPECIFY) ACTG. DEPUTY M.D. MEDICAL EXAMINER | | | | | DATE SIGNED 5-18-79 | |
| EXAMINER'S NAME (TYPE OR PRINT) Harry Paul Ross | | ADDRESS Chestertown Kent Co. Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-19-1979 | | 23c. NAME OF CEMETERY OR CREMATORY EMMANUEL CEM. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown Kent Md. | |
| 24. FUNERAL DIRECTOR NAME Kenneth W. Bailey | | | | ADDRESS Chestertown, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 23 1979 | | 25b. REGISTRAR'S SIGNATURE Harry Paul Ross |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

001-1-3

MAY 28 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH-16 20M
(VRA 15, 4) 7/78

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 79-12461 | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Emily Nevada Hull | | | 2a. DATE OF DEATH May 11, 1979 | | | 2b. HOUR 12:34A^M | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH October 5, 1912 | | 6 AGE (IN YEARS LAST BIRTHDAY) 66 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Kent | | | |
| 10. CITY OR TOWN OF DEATH Chestertown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Kent | | 13c. CITY OR TOWN Chestertown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 116 Elm Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Dowling | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen May Gill | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 218-32-9135 | | 17. INFORMANT ADDRESS Hospital Records, Chestertown, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA of GALLBLADDER 1560 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from April 27 , 19 79 , to May 11 , 19 79 , that (I) (we) lost saw the deceased alive on May 10 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Wayne D. Benjamin | | | | DEGREE M.D. | | | | 22c. DATE SIGNED 5/11/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne D. Benjamin M.D. | | | | 22e. ADDRESS Chestertown, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/13/79 | | 23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery near Chestertown, Md. | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME J. Wells Wells | | | | ADDRESS Chestertown, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 14 1979 | | 25b. REGISTRAR'S SIGNATURE Patrick McCreedy | |

MEDICAL CERTIFICATION

10451-05



FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-12462

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Esther Hutchins | | | 2a. DATE OF DEATH MONTH DAY YEAR May 13, 1979 | | 2b. HOUR 10:35 P |
| 3. SEX Female | 4. RACE Negro | 5. DATE OF BIRTH MONTH DAY YEAR April. 14 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD. | |
| 10. CITY OR TOWN OF DEATH Chestertown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital, Inc. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic Worker | | 12b. KIND OF BUSINESS OR INDUSTRY Domestic Work |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Kent | | 13c. CITY OR TOWN Chestertown |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walter NMN Rasin | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irene NMN Johnson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-14-4449 | | 17. INFORMANT ADDRESS Hospital Records - Chestertown, Maryland 21620 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intractable Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arterio Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Valvular Disease | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 12 , 19 79 , to May 13 , 19 79 , that (I) (we) last saw the deceased alive on May 13 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE K. K. Wun | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/21/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kim K. Wun, M.D. | | 22e. ADDRESS Chestertown, Maryland 21620 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5-19-79 | | 23c. NAME OF CEMETERY OR CREMATORY GRAVES CHAPEL | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE M. H. NORTON KENT MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME Donald W. Wally | | ADDRESS Chestertown, MD | | 25a. DATE REC'D. BY REGISTRAR MAY 23 1979 | |
| 25b. REGISTRAR'S SIGNATURE Theresa Kelly | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

0-15/85



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. |
|--|--|---|--|---|--|---|--|--|--|----------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Matilda Mayola Jones | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 5, 1979 | | | 2b. HOUR 8:10 PM | | |
| 3. SEX Female | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR 3 30 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD. | | | | |
| 10. CITY OR TOWN OF DEATH Chestertown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Delaware | | 13b. COUNTY New Castle | | 13c. CITY OR TOWN Wilmington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 502 E. 5th Street | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Leonard NMN Banks | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude NMN Brown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-20-7423 | | 17. INFORMANT ADDRESS Medical Records Kent & Queen Anne's Hospital | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis 0389 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Uncertain intra-abdominal source DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 3, 1979 to May 5, 1979 , that (I) (we) lost saw the deceased alive on May 5, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE C.G. Baumann, M.D. DEGREE ATTENDING PHYSICIAN MEDICAL <input checked="" type="checkbox"/> DIRECTOR STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 5/7/79 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.G. Baumann, M.D. | | | | 22e. ADDRESS Chestertown Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SIFY) BURIAL | | 23b. DATE 5-10-79 | | 23c. NAME OF CEMETERY OR CREMATORY UNION CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Worton Kent Md. | | | | |
| 24. FUNERAL DIRECTOR NAME Kenneth W. Wally ADDRESS Chestertown Md. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 23 1979 | | 25b. REGISTRAR'S SIGNATURE Anthony M. Brady | | | | |

12-15-88

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy performed.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|---|---|------------------------------------|--|---|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. 79-12464 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | |
| Mary Frances Manley | | | | | | May 23, 1979 | | | 11:00P _M | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | White | | July 22, 1912 | | 66 YRS | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Virginia | | United States | | | | Kent MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Chestertown | | Kent & Queen Anne's | | | | Housewife | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13a. INSIDE CITY LIMITS? | | | 13b. STREET ADDRESS | | | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | Route 1, Box 168-C | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | |
| James Edward Lipscomb | | | Lucy Hynson | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | |
| No | | | 215-20-4430 | | | Hospital Records, Chestertown, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia + COPD</u> | | | | | | | | | | 2 wk + yrs | |
| 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u> | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <u>Diabetes mellitus</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | |
| 22. I certify that (I) (the hospital) attended the deceased from May 16, 1979, to May 23, 1979, that (I) (we) lost saw the deceased alive on May 23, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. | | | | | | | | | | | |
| 22a. SIGNATURE DEGREE | | | | | | 22b. ADDRESS | | | 22c. DATE SIGNED | | |
| Harry Paul Ross M.D. | | | | | | Chestertown, Maryland | | | 5-24-79 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| burial | | | 5-26-79 | | Double Creek Church Cem. | | near Crumpton, Q.A. Md. | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Helfenbein-Hubbard Funeral Home, Chester, Md. | | | | | | MAY 31 1979 | | [Signature] | | | |

BP

DHMH-16 20M
(VRA 15, 4) 7/78

18-12-84

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

BP
DHMH - 16 50M 7/77
(VR A 15 (4))TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 79-12465 | |
|--|--|---|--|---|--|---|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LESSLE SUTTON NEWNAM | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 16, 1979 | | 2b. HOUR 1:15 AM | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 6, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Massey | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| 13a. STATE Md. | | 13b. COUNTY Kent | | 13c. CITY OR TOWN Massey | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Sutton | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Staats | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No. | | 16b. SOCIAL SECURITY NO. 213-74-9307 | | 17. INFORMANT ADDRESS W. Robert Newnam, Jr. Massey, Md. 21650 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio sclerosis CVS 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 78 546 79 | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-16-79 to 5-16-79 , that (I) (we) lost 19 saw the deceased alive on 5-16-79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Robert W. Farr DEGREE | | | | 22c. DATE SIGNED 5-16-79 | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr, M.D. | | | | 22e. ADDRESS Chestertown, Md. 21620 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/19/79 | | 23c. NAME OF CEMETERY OR CREMATORY Massey Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Massey, Kent, Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Howard E. Fellows, Millington, Md. 21651 | | | | 25a. DATE REC'D. BY REGISTRAR MAY 23 1979 | | 25b. REGISTRAR'S SIGNATURE Robert W. Farr | | | | | |

88-151-28

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-12466

| | | | | | | |
|---|--|--|--|---|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dewey Sterling Price | | | 2a. DATE OF DEATH MONTH DAY YEAR May 22, 1979 | | 2b. HOUR 5:35 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 1 23 99 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? America | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD. | | | | |
| 10. CITY OR TOWN OF DEATH Chestertown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Kent | | 13c. CITY OR TOWN Rock Hall | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jarret NMN Price | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Ford | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-09-1051 | | 17. INFORMANT ADDRESS Hospital Records Chestertown, Md. 21620 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic encephalopathy 5715 DUE TO, OR AS A CONSEQUENCE OF GI bleed (b) DUE TO, OR AS A CONSEQUENCE OF Cirrhosis of liver (c) | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 15, 1979 to May 22, 1979 , that (I) (we) last saw the deceased alive on May 22, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Pak-Chun Chan | | DEGREE MD | | 22c. DATE SIGNED 5/23/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Pak-Chun Chan, M.D. | | 22e. ADDRESS Chestertown, Md. 21620 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/24/79 | | 23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md. | | | | | | |
| 24. FUNERAL DIRECTOR NAME William Wells | | ADDRESS Chestertown, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 28 1979 | | |
| 25b. REGISTRAR'S SIGNATURE Patricia McCreedy | | | | | | |

BP

10-11-88

CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|------------------------------|--|--|---|---------------------------------|--|------------------------|--|--|
| 1. DECEASED-NAME (Type or print) | | First | Middle | Last | 20. DATE OF DEATH | | 2b. HOUR | | |
| FRANKLIN | | E. | PRICE, SR. | | May 23, 1979 | | 2 P M | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| male | white | | May 23, 1917 | | 62 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Maryland | USA | | | | Kent Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Chestertown | | RFD Quaker Neck | | Maintenance Various | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| STAMaryland | | Kent | | Chestertown | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | RFD Fairlee | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | First Middle Last | | | | | | | |
| Frank C. Price | | Nora Crouch | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| yes | | WW 2 | | Hester wife | | Hester Price RFD Chestertown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January</u> , 19 <u>60</u> , to <u>May 23</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11-21</u> , 19 <u>78</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | | | |
| <u>A.C. Dick</u> | | | | 5/23/79 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | |
| A.C. Dick | | | | Chestertown, Md. 21620 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 5/26/79 | | St. Paul's Cem. | | Near Chestertown, Md. | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| <u>Arthur Wells</u> | | | | MAY 28 1979 | | <u>Patrick McCreedy</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS

Know all men by these presents, that _____

of the County of _____ State of _____

do hereby certify that _____

has been duly elected _____

and has taken the oath of office and qualification _____

and is now acting as _____

Witness my hand and seal _____

at the City of _____

this _____ day of _____

19____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM-16 20M
(VRA 15, 4) 7/78

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR P M | |
| Susie Elizabeth Wetmore | | | | | | | | May 3, 1979 | | 1:00 P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN | |
| Female | | White | | February 24, 1887 | | 92 YRS | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Kent County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Chestertown | | Kent and Queen Anne's Hospital | | | | | | Housewife | | - | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| Maryland | | Queen Anne | | Crumpton | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | P.O. Box 191 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| John Robinson Casey | | | | Annie Isabelle Ashley | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | | | 213-22-5543 | | Hospital Records-Chestertown, Maryland 21620 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - <u>Acute Renal Failure - Uremia</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Renal Failure</u> (c) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-26-</u> <u>1979</u> to <u>May 3</u> <u>1979</u> , that (I) (we) last saw the deceased alive on <u>May 3</u> <u>1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>MA Wilson</u> | | | | DEGREE <u>M.D.</u> | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| Patrick A. Molony, M.D. | | | | Chestertown, Maryland 21620 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 5-5-79 | | Wesley Chapel Cemetery | | Rock Hall Kent Co. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Helfenbein-Hubbard F.H. Chestertown, Md. 21619 | | | | | | MAY 14 1979 | | <u>Patrick A. Molony</u> | | | |

U.S. - 1